TEXAS
Health and Human
Services Commission

Date

Caseworker
Office Address and Telephone No.

Client Name and Address:

Notification of Community Care Services

☐ **You are eligible to receive the following services:**

1. ____________________
per ____________ **effective** ____________ **.**

2. ____________________
per ____________ **effective** ____________ **.**

3. ____________________
per ____________ **effective** ____________ **.**

☐ **Pending final medical approval.**

☐ **You must pay** **$**____________ **on** ____________

and then pay **$**____________**per month, effective** ____________ **.**

You must report any changes in your income, assets, address, or condition within 10 days of the change.

☐ **The service you have been receiving,** ____________ **,**
will be changed to ____________ **beginning** ____________ **.**

☐ **Pending final medical approval.**

☐ **Your copayment will change to**
$ ____________**per month, beginning** ____________ **.**

☐ **You are NOT eligible to receive** ____________ **,**
because

☐ **The service you are receiving will end** ____________ **; HB Ref.** ____________ **.**

Comments (up to 5 lines):

Form H2065-A / 09-2004

See page 2 for a statement of your rights.

If you have any questions concerning this notice, contact the case manager shown on page 1.

YOU MAY REQUEST A HEARING TO APPEAL THE DECISION SHOWN ON PAGE ONE. You lose the right to appeal this decision 90 days from the date of this letter. If you are currently receiving services and request a hearing within 12 days from the date of this letter, you may be able to continue receiving your current service(s) until the hearing is completed. If the result of the appeal agrees with the action described on page 1, you may be asked to pay back the cost of services provided to you during the appeal period.

If you request a hearing, you may represent yourself or you may be represented by an authorized representative, a relative, a friend, or legal counsel. If you, your representative, or the hearing officer requests, your case manager may be present at the hearing.
IF YOU WANT A HEARING, please check the box at the bottom of this letter, sign your name, enter the date, and return this letter to your case manager listed on page 1. Keep the copy of this letter for your information. You may also request a hearing in person or by telephone.

IF YOU DO NOT WANT A HEARING, do not return this letter. If we have not received your hearing request within 12 days from the date of this letter, we will complete the action explained on page 1. If we have not received your request for a hearing within 90 days from the date of this letter, your right to a hearing is lost.

Whether or not you want a hearing, you may request a conference to discuss your situation with supervisory or management staff in the department. If you want a conference, contact the case manager to make the arrangements.

☐ **REQUEST FOR HEARING (Check this box ONLY IF you want a hearing.)**

I file this as my appeal and request for a hearing before an HHSC officer. I understand that if I continue receiving services and if the hearing officer decides the action taken is correct, I may be asked to pay back the cost of some or all of the services I received while this hearing was pending.

Signature–Client ______________________ Date

DENIED MEDICAID RECIPIENTS: The Department of State Health Services will send you a Certificate of Coverage. You can use this Certificate to prove how long you had Medicaid coverage if you enroll in another medical plan which has a pre-existing condition clause. If you do not receive the Certificate within two weeks after you receive this notice, or if you lose the Certificate and need a replacement within the next 24 months, you may request a Certificate by calling 1-800-723-4789.